

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011133	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/26/2019
NAME OF PROVIDER OR SUPPLIER CLINIC FOR WOMEN		STREET ADDRESS, CITY, STATE, ZIP CODE 3607 W 16TH ST STE 2B INDIANAPOLIS, IN 46222		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	<p>INITIAL COMMENTS</p> <p>This visit was for one State abortion clinic complaint investigation.</p> <p>Complaint Number: IN00283498</p> <p>Unsubstantiated: Lack of Sufficient Evidence</p> <p>Date: 2/26/19</p> <p>Facility Number: 011133</p> <p>Clinic for Women is in compliance with 410 IAC 26-4-1 Governing Body, 410 IAC 26-9-1 Medical Staff and 410 IAC 26-10 Patient Care and Nursing Services.</p> <p>QA: 3/4/19</p>	T 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE